THE CHIRONIAN

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THE CHIRONIAN

"In Essentials, Unity; In Non-Essentials, Liberty; In All Things, Charity."

VOLUME XXXIII JUNE 1917 NUMBER 12

Treatment of Diabetes*

BY

L. R. BOYNTON, CLASS OF 1902.

LEAVING out the history, cause, pathology and diagnosis, we omit a lot of interesting material, as well as some dry matter, and plunge directly into the treatment which may be divided into Prophylactic, Mental, Clinical, Dietetic and Medicinal.

As the disease is considered to a certain extent hereditary, by early prophylaxis we may avoid the disease or perhaps keep it under control so the patient may have a long, comfortable life. Attention should be paid to the general health, as, care of the teeth, skin, bathing, bowels, and digestion. It is well to put these people on a diet every few months. If married, and one partner has diabetes and the other subject to it by hereditary, it is considered best for them both to partake of the same diet, and occupy separate beds.

We should be honest and frank with these patients that they may diligently follow the diet and treatment for long periods without becoming discouraged, but at the same time do nothing to keep them frightened or nervous as neurosis aggravates diabetes and this cautions us not to examine the urine too frequently or the mental effect may be bad.

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*Read before the March meeting of the Helmuth Club.

It is well to keep the mind busy and active, and body occupied with pleasant congenial work or exercise to keep the mind away from self, and the body strong.

The climate should be even and mild. The fact of mountain or seashore does not have any direct influence.

Frequent baths will help to keep the skin active, the lukewarm bath probably best, but the cold bath may be indulged in by the more robust. Turkish baths and massage occasionally are helpful. Silk and flannel underwear are recommended, but we should not forget the linen mesh.

Diet is the most important part of the treatment and all starchy and saccharine food is restricted.

The factors in diet to be considered are appetite, digestion, the blood forming functions, weight, general tone and the condition of the various systems.

The first trial of the diabetic diet is the elimination of bread and potato and the restriction of quantity.

The quantity of energy in food is determined by its coloric value as the calorie is the unit of energy.

We can figure the amount of food required per weight of the body. Weight in kilograms multiplied by calories gives the right amount. An adult requires for every kilogram or 2 1-5 pounds of weight 35 to 40 calories.

It has been found that the longer sugar can be kept from the urine the greater the tolerance in the system of carbohydrates. If some of the intake is converted into glucose and lost in the urine there is a loss in the number of calories and therefore in nutrition. Destruction of tissue in the patient takes place and a loss of weight.

The first rule is to restrict the diet, both as to quality and quantity, and weigh patient.

When the weight of patient diminishes without sugar or acetone in the urine the quantity of food should be increased.

If the weight of the patient is diminished *with* sugar and acetone shown in the urine the *quality* of the diet must be changed and we must find out whether the fats or the albumens are producing the acidosis.

The usual diet consists of meats (except liver), fish, eggs, milk, butter, cheese, green vegetables, ripe fruits (except grapes), gluten bread, brown bread and bread made from almond flour.

Some authors will not use cooked fruits.

The alkaline mineral waters such as Vichy, Seltzer, Carlsbad, etc., are mentioned, but some authors say common water is better.

Some patients seem to do well on the skimmed milk diet.

The test diet, at Johns Hopkins Hospital, is—Breakfast—tea, boiled ham, one egg.

Luncheon—cold roast beef, cucumber or celery, vinegar, olive oil, whiskey, water, coffee, plain.

Dinner—clear bullion, roast beef, butter, green salad, vinegar, olive oil.

Supper—2 eggs, raw or cooked; water.

This, in the proper proportion as to weight, gives 200 grammes albumen and 135 grammes of fat.

When the urine has been free from sugar several days white bread or potato or other starch diet may be added in small and increasing quantity till sugar appears in the urine, then keep just below this quantity; but it is best to return to the test diet for a period every 3 or 4 months.

An important point is the prevention of harm from a number of substances which occur in metabolic changes, generally called acetones, butyric acid, the main substance which oxydizes and becomes acetone, an end product.

If this oxydation is incomplete we have acidosis, productive of coma, and must arrange the diet to prevent the acidosis.

When acidosis is evident alkalies are given, namely, Soda Bicarbonate, enough to make the urine alkaline.

Van Noorden adds alkalies to the first diet, as he found that the complete withdrawal of the carbohydrates leads to acidosis.

Constipation must be avoided, as it causes autointoxication, which, in turn, produces acidosis. The alkaline or saline mineral waters and salts are probably best to use.

Treatment of the individual patient is more important than treating the disease itself.

Under medical treatment both schools of medicine say it is very unsatisfactory. One writer said he never knew of a case of diabetes being cured, but the urine had been made sugar free and kept so by watchful dieting and using remedies.

Under the old school treatment opium seems to hold first

rank, the claim being that it checks and prevents the formation of sugar at least, for a time.

Forchheimer says one of his medical friends, in a case of pyelitis in a diabetic, found accidentally in giving urotropin for the pyelitis that the sugar disappeared. Since then he gives it to all patients that he cannot trust to be true to diet, giving five grains three or four times a day. Atropine sulphate and arsenic are also given, but it is claimed that so much arsenic must be given that there is danger of poisoning.

The homeopathic list is usually Uranium nit., Phosphoric ac., Syzigium arsenicum, Nux vomica, Chamomilla, Kreosote, Opium, Lachesis, Tarentula, Curare.

We do not find Iodum mentioned, but it seems as though it ought to be useful, for we find under Stomach—ravenous appetite and great thirst, yet patient loses flesh. Urine—frequent and copious.

Diabetic coma is the end and usually not helped. It has been treated by giving 5 per cent. solution of Soda Bicarbonate intravenously—250 c.c. every three hours till 1,000 c.c. are taken. It is also given by the rectum. By this method patients have been revived enough to make a clear will before relapsing again.

Some French physicians have tried pancreatic juice or pancreatic extract in treating diabetes, giving it by hypodermatic injections, but complications from traumatism are apt to occur and that brings us to the complication of gangrene, which is largely surgical and, usually, not satisfactory.

This oneness of life forbids the idea that any bodily disease can remain completely and absolutely local so long as it is not confined to a part of the body entirely shut off from all the rest. The remainder of the system simultaneously suffers more or less, and betrays its suffering in this or that symptom. Every powerful medicine produces amongst other actions an effect upon a disease apparently local, even when applied to a distant part or taken internally, and the remedy specifically fitted for the general disease (of which the local manifestation is always but a part or symptom) relieves also the local affection which is far removed and apparently isolated.—*Organon of the Rational Art of Healing.*

The Teaching of Urology at Flower Hospital

BY

FAREL JOUARD, PH. D., PROFESSOR OF UROLOGY.

IN these days of highly specialized diagnostic methods it is hardly necessary to offer a *raison d'etre* for the study of urine. In view, however, of the many conflicting opinions on this subject voiced now and anon by "those who ought to know," it is becoming more and more essential that the physician-to-be, in order to be able, later, to estimate correctly the various theories, hobbies and prejudices thrust upon the medical profession in this line, should be not only acquainted with but thoroughly versed in the fundamentals of urology. To cite an illustration: For a great many years, in fact, as far back as most of us can remember, it has been almost universally admitted among the medical profession that if the examination of urine is *of any use whatever,* it is valuable in the diagnosis of *nephritis,* at least. And yet, during the past year there appeared in one of the leading laboratory journals a lengthy article, based ostensibly on research, but claiming that the results of a urine examination are of little, if any, significance in ascertaining the condition of the kidneys. Careful perusal of this article, to be sure, reveals nothing but experiments of the most slipshod type and hasty generalizations therefrom; but unless the student and the young practitioner have learned, by careful study and from actual experience, just what a thorough examination of urine means, how it is performed, and whether or not its results corroborate the clinical findings, a dissertation such as the one referred to is likely to be taken by them a great deal more seriously than it deserves. Hence the value of definite, practical training in the subject for the medical undergraduate.

During the past year important changes have been introduced in connection with the course in urology in the college. Heretofore it was customary to include the study of the chemical analysis of urine—or as much of it as time allowed—with the sophomore course in physiological chemistry, while instruction in

urinary microscopy was given the following year to the juniors. This arrangement of courses was open to two serious objections. First, the subject of urinary chemistry, if taught—as it should be in a medical college—with due emphasis laid upon clinical aspects and practical methods, was likely to encroach too much on the more general course in physiologic chemistry of which it formed a part. Secondly, when the chemical and the microscopical instruction were given in two successive years, the hiatus thus caused made it difficult for the student's mind to form a correct estimate of the relative importance of these two phases of the subject and to realize their intimate connection. It was, therefore, decided to isolate the study of chemical urine analysis from the course in physiologic chemistry and combine it with that of urinary microscopy under a single chair of urology.

Hereafter, therefore, urology is to be taught in the second year, the first semester being devoted to the chemical side of it, and the second to the microscopic. Two hours a week during the entire college year are assigned for the purpose, the greater part of which time the student spends in the laboratories. Each student is equipped with a full set of the apparatus and reagents necessary for performing all the important physical and chemical tests, both qualitative and quantitative. Stress is laid on exact laboratory technique, especially in connection with volumetric analysis, and when the student has been thoroughly drilled in the various methods, he is required to perform accurately a number of complete chemical analyses.

The study of urinary sediments follows in the second semester. Here the student is made familiar with all the important features to be found microscopically in the urine, material being provided and selected from the wards of Flower Hospital, with the co-operation of the department of clinical pathology. First, the various crystalline and amorphous deposits are studied; then follow in turn the detection and differentiation of epithelia, the recognition of the various forms of casts, of mucus, connective tissue, tumors, parasites, extraneous matter, and so forth. In all of these exercises with the microscope the student is required to measure and draw what he sees, especially in the case of epithelia. Finally, the principles of urinary diagnosis, which have been gradually developed during the course, are taken

up systematically and the student is taught to apply them in the cases which he is actually studying. Throughout the course the laboratory session is generally preceded by a brief lecture or quiz, and Heitzmann's *Urinary Analysis and Diagnosis* is used as a text-book to supplement the lectures.

While the course is closely related to that in clinical pathology and forms a partial introduction to that subject, it is intended, primarily, as has been shown above, to be educative on broad lines, both as to laboratory technique and as to knowledge of the principles of a subject where skepticism is generally due to ignorance.

It may well be that there are yet other diseases attributable to a "miasm" which we cannot yet demonstrate, besides those that belong to certain localities and climatic conditions and those that are endemic in certain scattered regions: *e g.,* autumnal marsh-fever, yellow fever, sea-scurvy, frambesia (yaws), pellagra, etc. Further, there are a few diseases arising either from a single uniformly acting cause or from a combination of several definite causes acting simultaneously, which can readily be classed together to some extent, as, for instance, gout, and possibly, also membranous croup and Miller's asthma. These diseases are little less deserving of their special names because the symptom-group remains tolerably constant, on the whole, for each of them, and therefore each is adapted to a definite and almost established treatment.—*Organon of the Rational Art of Healing.*

Lepidium bonariense, a Brazilian cress, belonging to the same family as the English (common garden) cress, in its proving affected the left side principally, according to the text. With heart symptoms, numbness and pain in left arm, and sensation of sinking in the pit of stomach. Lancinations in left side of head, pain in left brain spreading to occupit and nape. Left side of nose swollen and painful; heat in left side of face, lancinating pain in left chest. Left arm pain so intense can scarcely raise it; cramping pain in left hand. Pain from left hip to knee.—*Trans. International Hahn. Association,* 1914.

The Homeopathic Medical Society of the State of New York

THE sixty-fifth annual meeting of the Homeopathic Medical Society of the State of New York was held in New York City on April 10th and 11th. The opening business session and the scientific session were held in the Convention Room of the Hotel McAlpin on Tuesday afternoon. The election of officers took place at the business session and the following members were elected for the new year: President, Dr. Rudolph F. Rabe, of New York; First Vice-President, Dr. Frederick M. Dearborn, of New York; Second Vice-President, Dr. Arthur R. Grant, of Utica; Third Vice-President, Dr. Sprague Carleton, of New York; Secretary, Dr. Reeve Turner, of New York; Treasurer, Dr. Stewart S. Piper, of Elmira; Necrologist, Dr. Glen I. Bidwell, of Rochester. There were from seventy-five to a hundred and twenty-five members present at these sessions. The scientific session consisted of An Oration in Medicine, by Dr. W. H. Watters, Pathologist to the Massachusetts Homeopathic Hospital and Professor of Pathology at the Boston University School of Medicine; An Oration in Surgery, by H. L. Northrop, F. A. C. S., Professor of Anatomy of the Hahnemann Medical College of Philadelphia, and surgeon to Hahnemann Hospital of Philadelphia; a propagandistic session contributed by Drs. W. A. Dewey, of Ann Arbor, Mich., and C. E. Sawyer, of Marion, Ohio, both being prominent members of the American Institute of Homeopathy. Dr. Dewey gave a talk on homeopathic properties at home and abroad and illustrated the same with slides. Dr. Sawyer spoke on organization, co-operation and federation between the American Institute and the State Society.

Hahnemann's birthday, April 10th, was appropriately celebrated by a banquet held in the Ball Room of the Hotel McAlpin, at 7 P. M. Two hundred and thirty-three diners enjoyed to the full extent the remarks of the president, Dr. G. R. Critchlow, of Buffalo, and the speakers, Drs. W. W. Van Baun, W. A. Dewey, R. S. Copeland and C. E. Sawyer. It has seldom been the privilege of medical men to listen to toasts all responded to by their

own brethren, and all so eloquently. The banquet was fittingly closed by an hour and a half of vaudeville furnished by the private entertainment department of the B. F. Keith Theaters.

The second day, Wednesday, April 11th, was spent at the Metropolitan Hospital. At the regular business session a resolution, suggested by Dr. Sawyer, making federation between the American Institute of Homeopathy and the New York State Society immediately effective was passed. The remainder of the morning was spent in inspection of the Hospital. Lunch was served at the Nurses' Home by the Medical Board, at which a hundred and forty-six physicians were present.

The Chairman of the Local Committee of Arrangements, Dr. F. M. Dearborn, introduced the First Deputy Commissioner of Charities, Henry C. Wright, who spoke as follows:

"I didn't know I was going to say anything at this particular time. It seems very untimely when you are so hungry, because I do not think that anything so tenuous and vapory as words will satisfy you in your present condition.

"I want, on behalf of Commissioner Kingsbury and the Department, to welcome your Society to New York and, especially, to the Metropolitan Hospital; and Commissioner Kingsbury wants especially to express his regret at not being able to be here. He came to the office in his machine this morning, but he had a very severe cold, and was subsequently attacked with pleurisy, so that he had to go home again and immediately to bed. Otherwise he had intended to be here and to enter into this welcome. We especially welcome you, not only because of your opportunity to visit here at this hospital, but because it emphasizes what this hospital means to you and what your society or association may mean to the hospital.

"I presume a great many of you are familiar with the Metropolitan Hospital, indeed, I presume a good many of you have served here as internes; but, regardless of that fact, you may not hold the picture in view as a whole in its relation to other things. One wants to bear in mind that this hospital is probably the largest hospital in the United States. I know of none larger. Do you? I think it is the largest in the United States purely as a hospital. It has as large a variety of services as any of the hospitals, a larger variety of services than most private hospitals.

For that reason, and the large number of patients that are here, it affords a better opportunity for the training of internes than most any of the other hospitals; probably not better than some of the other large city hospitals, but better than most private hospitals.

"We have been laying great stress during the past year, or I might say the past two or three years, upon the improvement in our hospital services and in our medical services. We have been doing that because we sincerely believe in those things. We have been casting back over the history of our hospital and medical services in New York City, and we have found that they have improved from age to age, or from decade to decade, but have not yet gotten to the point of efficiency of service, in better organization which helps to promote that efficiency; and it has been the ambition of the Department to help, in its small way possibly, to bring the hospitals of this Department to as high a grade of efficiency as can be found in the private hospitals of this city.

"We are not quite there, but we are almost. For instance, we have as good operating services and as good operating rooms as will be found in any hospital in this city. We have just completed new wards to the City Hospital at the southern end of this island, which are equal to and probably not excelled by any in New York City. And we have been laying great stress upon reorganization, not because of reorganization, but because we have been sincerely and deeply interested in efficient operating; and I don't mean efficient in the word-a-day sense in which we use it to-day, to destroy the real meaning of the word; but I think our medical men to-day are coming more and more to feel that medicine is a great deal more of a science than it used to be—not yet entirely out of the realm of guesswork, unfortunately—of course, we wouldn't say that out loud—but a good deal of guesswork yet, still with a much greater approach to the basis of scientific accuracy than it used to be; scientific advances which depend upon devices and machinery and equipment and the men who know how to use these things, and the men who will use them carefully and efficiently.

"Now, we have been laying stress upon the equipment of our hospitals—I mean equipment which helps your doctors to diagnose and your surgeons to operate. We have not got them anywhere near where we want them. For instance, at the present

time we are planning to ask the city for about fourteen or fifteen thousand dollars this spring to bring our X-ray equipment up-to-date, and I guess that some of the money will come to this hospital; indeed, it is quite likely that it will, because our plant here is one of the first of the city hospitals, it is probably ten years old, and must need a good deal of replacing.

"There is not much use in laying emphasis upon such matters unless there is entire sympathy and co-operation on the part of the men who are to use the apparatus, on the part of the men who do the services in the hospitals. We have laid considerable emphasis upon the form of organization while we have been in office called continuous service, and we have not laid that emphasis because we have any particular uses for continuous operation—except this, that in any form of organization it only becomes efficient to the extent that you have directing and controlling heads. That is just as true in medicine as it is true in business or as it is true in educational matters, or as it is true in any line. It is for this reason we have laid emphasis upon such things, and because such forms of organization have proven themselves effective and efficient in some of the best institutions, like Johns Hopkins and the Massachusetts General. We introduced it in the Greenpoint Hospital a year and a half ago, and we want to say that we have been abundantly pleased with the very efficient work that is being done there—I think the highest of any of the hospitals of this department.

"Now, it is only to the extent that the staff men, the attending men, see the necessity of accurate, efficient, painstaking service that such things can be brought about. I know you who belong to this school, the Homeopathic School, must feel pride in the fact that there is under your direction and under your service the largest hospital in the United States, and I sincerely hope, and, speaking on behalf of Commissioner Kingsbury, I sincerely hope that you will use every effort to see that there is not only organization, but harmonious organization, such organization in this hospital as will produce the best results that can be produced in a hospital. I am very sure you would not want better results produced in an allopathic than can be, should be and will be produced in a homeopathic hospital, and I am very sure you would work to that end.

"Let me give you another little piece of cheering news: Under this school is now this hospital, the largest in the United States. Under this school also is to be built soon, and I hope it to be actually under contract within a month or six weeks, what seems to me the best hospital of its size—three hundred beds—in the United States, the Cumberland Street Hospital, so that under your direction you will have not only the largest, but, we think, the best equipped and best organized and best planned hospital in the United States. So you have something to look forward to. We sincerely hope that in such meetings as you are having here you will lay stress upon co-operation and organization and efficiency, so to produce out of these hospitals, under your direction and services, the best results that are obtainable under the knowledge of modern medicine."

Dr. Dearborn then introduced Dr. Rankin, President of the Medical Board, who welcomed the guests.

The afternoon was devoted to clinics embracing medicine, surgery and the various specialties, at which two hundred and fifty were in attendance. Detail of the clinics follows: Department of Medicine, service of E. Guernsey Rankin, clinic conducted by Dr. D. B. Jewett, of Rochester; Department of Neurology, service of Clarence C. Howard, clinic conducted by Dr. R. M. Schley, of Buffalo; Department of Dermatology, service of Frederick M. Dearborn, clinic conducted by Dr. Dearborn in the absence of Dr. Ralph Bernstein, of Philadelphia; Department of Obstetrics, service of John H. Storer, clinic conducted by Dr. Storer in the absence of Dr. E. H. Wolcott, of Rochester; Department of Pediatrics, service of Reuel A. Benson, clinic conducted by Dr. Benson in the absence of Dr. C. R. Green, of Albany; Department of Surgery, service of Clinton L. Bagg, clinic conducted by Dr. S. R. Snow, of Rochester; Department of Surgery, service of William F. Honan, clinic conducted by Dr. A. R. Grant, F. A. C. S., of Utica; Department of Surgery, service of Gove S. Harrington, clinic conducted by Dr. A. B. Van Loon, F. A. C. S., of Albany; Department of Urology, service of Sprague Carleton, clinic conducted by Dr. Leon T. Ashcraft, F. A. C. S., of Philadelphia; Department of Ophthalmology and Otology, service of Charles C. Boyle, clinic conducted by Dr. Boyle in the absence of Dr.

J. I. Dowling, of Albany; Department of Rhinology and Laryngology, service of Harold A. Foster, clinic conducted by Dr. J. R. Honiss, of Rochester, and Department of Orthopedics, service of Anson H. Bingham, F. A. C. S., clinic conducted by Dr. L. A. Whitney, of Rochester.

The details of the meeting were arranged by the following members, as the Local Committee of Arrangements: Chairman, Dr. Frederick M. Dearborn; Secretary, Dr. Bert B. Clark; Treasurer, Dr. Joseph H. Fobes; with Drs. Cornelia C. Brant, Sprague Carleton, Harold A. Foster, William Tod Helmuth, Llewellyn E. Hetrick, William F. Honan, Clarence C. Howard, Grace M. Kahrs, Samuel B. Moore, Rudolph F. Rabe, Jeremiah T. Simonson, Philip C. Thomas and Reeve Turner. Drs. Honan, Fobes, Hetrick and Foster were, respectively, Chairmen of the Sub-Committees on Program, Ways and Means, Place of Meeting and Entertainment.

This meeting probably stands as the most successful the New York State Society has ever had, nearly four hundred different physicians being in attendance at one session or another.

As to the first point, the enormous number and variety of diseases might easily persuade us into a conviction that they cannot possibly be individually considered or even retained in the memory; and that they cannot be cured unless a comprehensive survey be first made of them and a separation effected (upon the basis of certain common characteristics), into a few small classes, each of which may then with comparative ease be treated as one disease by a common method.—*Organon of the Rational Art of Healing.*

Diseases, infirmities and illnesses present, however, appearances so endlessly various that such a forcible grouping into separate divisions, however apparently necessary, can hardly serve any useful purpose from the point of view of cure.—*Organon of the Rational Art of Healing.*

Some Cases From the Rectal Clinic at Flower Hospital

BY

ORLANDO R. VON BONNEWITZ, M. D., ASSISTANT PROFESSOR PROCTOLOGY,

AND

FRANCIS C. FERGUSON, M. D., CLINICAL ASSISTANT.

IT would seem that the 6th anniversary of the establishment of a rectal clinic for the teaching of proctology to the students of the college would be an opportune time to report some of the interesting cases we are treating in the hospital and clinic.

Many of the alumni who did not have this advantage during their college course would no doubt be interested in the kind of work the students are receiving for two hours twice a week during the entire year.

Each case is given to a student to examine and make a diagnosis after writing the history. We then analyze the case, devoting some time to the various complications in diagnosing, treatment or operation. All cases are operated under local or gas anesthesia if possible, the students assisting. The treatment and progress is followed from day to day until discharged.

This, I think, is a great improvement over the old way, where the case is not seen again after operation in the amphitheatre, so that they have no means of knowing whether it was a success or a failure.

The cases presented here are taken because of some interesting feature out of the ordinary.

CASE 1.—Angio-Papilloma. Mrs. N. W., age 34, was referred to the clinic June 9, 1912. Family history negative as to specific diseases. Alcohol and drugs denied. Married four years; no pregnancies. Menstrual history normal. Both parents died of normal causes. Patient was thin but not anemic; slight bleeding at stool for two years; had been treated for hemorrhoids by

various methods, and seven months previously had operation for same, but the bleeding did not stop. The past four months a stubborn diarrhea occurred, which was treated as tubercular. Abdominal examination was negative, digital examination revealed a large soft mass occupying the anterior two-thirds of the gut, and extending six inches into tne rectum. The ampulla was almost entirely filled. Proctoscopic view showed the mass as dark red and bleeding upon the slightest touch. The diagnosis above was confirmed by the laboratory. On July 2d we did a left inguinal colostomy, and she left the hospital in two weeks, reporting at the clinic for dressings. Her health improved greatly for three years and then declined and she was referred to the radium clinic for further treatment. She seemed to get some benefit at first, but the case was an inoperable one when first seen, and the systemic invasion so great we had but little hope, and she died some time later.

This is the type of case we cannot expect to do much with for the reason that we see them too late. It emphasizes the importance of carefully examining each case of constipation, diarrhea, "piles" or any complaint about the anus or rectum so that an early diagnosis may be made and suitable treatment administered.

Case 2.—Rectal prolapse, 3d degree, strangulated. Mrs. A. R. G., age 54, widow, five children. Entered the hospital May 19, 1914, complaining of "rectal tumor." She was very fat and weak, and had very floried color. Alcohol and drugs denied; family history negative. She had been referred to us from Bellevue Hospital. Examination showed the entire rectum prolapsed and strangulated, extending some nine inches out of the anus. Repeated efforts to replace had proved futile. On May 21st we operated, making six deep cuts with the Pacquelin cautery at equal distances around the gut, and then threaded two silk sutures through the walls and brought out on each side of the buttocks. A small triangular piece was cut from the anal margin and sutured. The gut was then replaced, after dressing with soda and calendula cerate, and the guy sutures drawn taut and tied. After four days the bowel was irrigated daily with saline solution through a bell-shaped tube for two weeks and the sutures removed. The result has been most gratifying, the constipation cured and there has been no prolapse since.

CASE 3.—Impacted rectum. Mr. G. A., laborer, age 54, widower, was found in a large factory nearly unconscious. Was brought to the hospital November, 1914, by the ambulance. He had been in a hospital for two weeks with typhoid fever (?), and was discharged six days ago as cured, although he had a slight diarrhea still present. He was taken to the medical ward, and after three days the diarrhea stopped and no movement could be induced for four days, when, I was asked to see him. Digital examination revealed a large tumor as large as an orange filling most of the rectum, with a small hole in the center. He was taken to the clinic and with the proctoscope the "tumor" could be seen, covered with a greyish deposit like skin. This was removed and a ball of hard, ancient feces was visable, with a small hole the size of a pencil in the center. Removing this ball was some job, as it was full of small sticks like broken toothpicks. His fever subsided at once and he made an uneventful recovery.

This, I believe, illustrates what I have always contended, that many cases of mild or "walking typhoid" are, in fact, severe types of systemic toxemia. I have had quite a number of these cases in private practice which cleared up at once under proper treatment.

This man had been a "pill eater" for years, and the bowels could only move when the feces was liquid enough to pass through the small opening in the mass.

CASE 4.—Pruritus ani. Mr. A. G., age 52; married; no children; street cleaner; was sent to our clinic by Dr. Le Roy Smith, of Bellevue, on May 16, 1915. Habits and family history negative. Four years ago first had itching about the anus, which gradually grew worse, especially at night. He had two skin tabs removed at a clinic without improvement. Three years ago he was operated at a large special hospital by a rectal surgeon; a Ball operation being performed. The result was what I have found to be the usual one, the flaps necrosed, leaving him with a hundred fissures in effect and the itching almost unbearable. Many times worse than before operation. His eyes were popping nearly out of his head, and he had the appearance of a man on the verge of insanity. He said he had not had much sleep for three months, and certainly was a nervous wreck.

The area around the anus was ulcerated and bleeding and extending for three inches about the orifice. Proctoscopic examina-

tion disclosed siv or eight ulcers the size of a dime, and extending throughout the rectum.

With one exception it was the worst case of pruritus I have ever seen. After irrigating him for three months I divided the rectum at the posterior commissure to overcome the stricture, and dissected out the remains of the tabs from the necrosed flaps. He has been back to work for some time and is greatly improved but still under treatment, as there is occasionally some itching. I do not believe in the Ball operation, as the relief only remains long enough for the severed nerves to unite, even if you do not get necrosis of the flaps, which occurs oftener than one would think.

Case 5.—Post-operative hemorrhage. Mr. S. R., age 35, salesman; single; admitted to the hospital Nov. 2, 1916, complaining of bleeding hemorrhoids. He was weak and white as muslin, dizzy and emaciated. Alcohol and drugs denied, but was an excessive user of cigarettes. Examination showed strangulated hemorrhoids, black and gangrenous, but no blood. He said they had been coming down at stool for several years, but he had always, until three days ago, been able to replace them. Several doctors had tried to put them back but were not able to do so. We considered him a bad operative risk, but yielded to his entreaties and operated on election day. During the operation he bled profusely on account of the rotten condition of the tissues, and we encountered several bad spurters. He left the table in good shape, but six hours later he blew the plug and dressings half across the bed. Dr. Balleu plugged again, but in two hours he did the same thing, losing in all about a pint or more of blood. I saw him at midnight, and after giving him 800 cc. saline we took him to the operating room, thinking a ligature had slipped or cut through. We found the operative field intact but a brisk hemorrhage coming from a point four inches up in the rectum from what apparently was an old ulcer . This was cauterized and the rectum packed high up. There was no further trouble and he left the hospital in a week.

I saw this case in my office after leaving the hospital and found two other large ulcers, which were undoubtedly specific, although he denied ever having had syphilis. Strangulated hemorrhoids and anal fissure are the only two ailments in which we do

not make a protoscopic examination, because of the pain in one and the impossibilty in the other. Most, if not all, of this means hemorrhage came from the ulcer and not the hemorrhoids. It is no wonder he was treated in Boston for two months for pernicious anemia.

I have seen many cases of secondary anemia due to but very slight and persistent bleeding from small "strawberry" internal hemorrhoids, where the amount of blood lost was so small you would not think it possible to produce such a grave condition.

Case 6.—Multiple fistula. Mr. H. F., age 37, bar tender; married; was brought to the clinic by Dr. Stern, a senior student, who said he had an anal fissure. I did not examine him until he was on the operating table, but he had a bad fissure on the left side of the anus. Under gas anesthesia we divulsed the sphincters and broke up the inflammatory adhesions in the levators as well. During the operation I felt a soft mass about four inches up, but could not make out what it was. He was quite comfortable after the operation. He returned to the ward, but during the night the left testicle began to swell. This continued until the next day when I had Dr. Carlton and Dr. Maeder see him, when the testicle was opened and two ounces of pus evacuated. This drained for two days when it stopped and the ischio-rectal fossa began to swell. I opened this two days later and got some six ounces of pus. Later, I operated the fistula, which I found had five branches, one extending nearly up to the recto-sigmoidal juncture.

This was an intensely interesting case, as I have never seen one that behaved in this manner before. Of course, the abscess and the fissure co-existed, but the fissure was no doubt present several days before the abscess formed, and what he thought was an aggravation from some medicine prescribed by his doctor was simply the forming of the abscess above.

Case 7.—Incontinance of feces repaired. Mr. A. G., 31; married; tailor; was sent to the clinic with a note asking that he be cared for, on May 3, 1916. The large hospital from which he was referred told him this was a "hospital for rectal diseases only," and they knew better how to care for such cases. The history shows he was suffering from an ischio-rectal abscess four weeks before (he had the original diagnosis slip), and was admitted to the hospital and operated upon, both muscles being divided. He

was kept in this hospital four weeks and the wound was dressed but three times a week during that time. As soon as he was strong enough to walk he was given this note and sent to us.

I have seldom seen such a sight as this was, and the students were amazed at his condition presenting. We could make out seven openings around the buttocks, into two of which we could introduce the finger for four inches. There was absolutely no control of the bowels, and it was no trouble at all to press out an ounce or more of pus from several sinuses.

We declined to have anything to do with the case, and sent him back to the original operator at the other hospital. He came to my house that night and begged so hard I consented to do what I could to repair the damage. We gave him an irrigating apparatus with instructions to use five gallons of water at 130 degrees daily for a week and then report at the clinic. Treatment was continued for five months before the tissues were in fit condition to risk operation for the fistulæ. The operation was successful in relieving the pus tracts, but we still had the incontinence. Six weeks later we cut down and sutured the cut ends of the external sphincter muscle, and made an artificial stricture at the internal sphincter, and the result has been 90 per cent. control, which is most gratifying to all of us.

I believe we are justified in feeling a certain amount of pride in the outcome of this case, for certainly it was a most hopeless one when we first examined him. Most clinical patients are convinced that anal fistula is an incurable disease, because of the many failures among their friends. As a matter of fact this deduction is in a sense correct, since the chief usually does the operation, and the orderly does the most important part, which is the dressings. The immense amount of work necessary to effect a cure does not usually appeal to the surgeon. Our experience demonstrates that an extensive fistula presents a new picture which requires skill and judgment every thirty-six hours, and if the orderly was competent to deal with this condition, he would not be an orderly. We cure fistulæ in our clinic because we watch them carefully from operation to discharge, and this means work.

The Chironian

The monthly Journal of the Alumni Association of the New York Homeopathic Medical College and Flower Hospital.

THE CHIRONIAN COMMITTEE

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EDITOR

E. R. Eaton, B. A., Class of 1919

The Editor is responsible only for opinions expressed in editorials.

EDITORIAL

OUR alumni will be interested in reading the letter that follows, recently received, advocating the election of our fellow alumnus, Frederick M. Dearborn, Class of 1900, to the presidency of the American Institute of Homeopathy. It would seem that an acquaintance with modern methods of organization and active participation in Institute affairs for seventeen years and a great capacity for work, not to mention enthusiasm and zeal for things homeopathic, would make Dr. Dearborn an ideal candidate for this important post of duty. We trust that our readers will do all in their power to further his election:

March 27, 1917.

My Dear Doctor:

The coming year will be vital in the history of the American Institute of Homeopathy, the official mouthpiece of our school. This body is now in the midst of working out plans for a reorganization and federation. The Trustees realize that this amalgamation of homeopathic interests is most important. The

success of this move promises a business organization and a close union of all homeopathic interests. It will create through greater publicity and propagandism a better general understanding and knowledge of Homeopathy, and in this way finally advance the interests of all societies, colleges, hospitals and individual practitioners of our school.

Some of the members of the Board of Trustees, being awake to the necessity of having an active, aggressive and loyal homeopath at the head of our national organization, have asked Dr. Frederick M. Dearborn to be a candidate for the presidency of the Institute. His friends have induced him to allow his name to be used and are deputizing themselves to work for his election.

Dr. Dearborn as an author, teacher and worker for Homeopathy is well known. He has been a member of the Institute for seventeen years, of the Board of Trustees for two years, and is familiar with and heartily in accord with the present reorganization work.

May we count upon your support?

Very sincerely yours,

Henry C. Aldrich, Minneapolis, Minn.
Leon T. Ashcraft, Philadelphia, Pa.
Maurice C. Ashley, Middletown, N. Y.
Benjamin F. Bailey, Lincoln, Neb.
Alfred W. Baily, Atlantic City, N. J.
Clarence Bartlett, Philadeelphia, Pa.
W. W. Blackman, Brooklyn, N. Y.
William Boericke, San Francisco, Cal.
Thomas H. Carmichael, Philadelphia, Pa.
Daniel E. S. Coleman, New York, N. Y.
George R. Critchlow, Buffalo, N. Y.
Ira O. Denman, Toledo, O.
Gilbert Fitzpatrick, Chicago, Ill.
Arminda C. Fry, Chicago, Ill.
Joseph H. Fobes, New York, N. Y.
Harold A. Foster, New York, N. Y.
Mary E. Hanks, Chicago, Ill.
Burton Haseltine, Chicago, Ill.
Margaret Hassler, Reading, Pa.
William Tod Helmuth, New York, N. Y.
Sarah M. Hobson, Chicago, Ill.
J. Richey Horner, Cleveland, O.
William H. King, New York, N. Y.
George W. Mackenzie, Philadelphia, Pa.
William J. Martin, Wilkinsburg, Pa.
Henry B. Minton, Brooklyn, N. Y.
Clifford Mitchell, Chicago, Ill.
J. Hebrert Moore, Brookline, Mass.
Herbert L. Northrop, Philadelphia, Pa.
Arthur B. Norton, New York, N. Y.
Scott Parsons, St. Louis, Mo.
Eldridge C. Price, Baltimore, Md.
Rudolph F. Rabe, New York, N. Y.
George Royal, Des Moines, Ia.
Charles E. Sawyer, Marion, O.
Ansel B. Smith, Grand Rapids, Mich.
Richard H. Street, Chicago, Ill.
William H. Vanden Burg, New York.
Florence Ward, San Francisco, Cal.
James W. Ward, San Francisco, Cal.
John E. Wilson, New York, N. Y.
E. Weldon Young, Seattle, Wash.

Fever Occurring During the Puerperium from a Clinical Standpoint.*

BY

WILLIAM DEFORREST VOORHEES, CLASS OF 1915.

THE subject matter for this paper has been gathered from some three hundred consecutive cases of labor which I have had the privilege to observe, and which, with the exception of about forty were conducted with the most approved obstetrical technic. About one case in every ten at some time during the fourteen days following delivery ran a temperature of over 100° F.

In classifying the causes of fever during the puerperium it is well to rule out those cases that have been running a temperature prior to the onset of labor. It is a simple thing to take a patient's temperature at the beginning of the first stage, and if it is elevated at that time it may save the physician a considerable amount of worry a few days later. It is also well to remember that not infrequently labor is induced by diseases running a febrile course. Excluding the acute infectious diseases, with which we are all familiar, it has been my experience that the most common cause of fever occurring prior to the onset of labor and continuing during the puerperium is tuberculosis. Not only do we get the afternoon febrile exacerbation of tuberculosis before and after labor, but in two cases I have seen it appeared only after delivery when there was a chronic fibroid phthisis. In both these cases it would be very difficult to say whether the labor was the cause of lighting up the old tubercular processes or whether the slight amount of ether used to produce analgesia was the factor aggravating the chronic lesion. The characteristic feature of the tubercular temperature is the evening aggravation. The temperature during the forenoon is normal, and even that during the late afternoon seldom exceeds 101° F. In following

*Read before the King's County Homeopathic Medical Society, March 27, 1917.

these cases, after the puerperium. I have found that they usually improve very readily with the appropriate treatment.

In normal cases, shortly after the child is delivered, we often find the patient having a chill, and if the temperature is taken shortly after the chill, we find a slight elevation—always below 100° F. Williams speaks of this type of chill as being purely neurotic in origin, and so it seems. The chill occurs too soon after delivery to be of infective origin and the non-continuance of the fever also corroborates this view.

Several times during the past winter I have seen fever during the puerperium caused by tonsillitis. On several occasions the fever has run along for three or four days and caused systemic disturbances such as muscular pains and pronounced lassitude. The fever has usually been lower than we might expect if we judged wholly by the patient's general condition. In fact, a simple tonsillitis seems to be able to produce more general debility than any other disease that has such slight pathological lesions. It is hardly necessary to speak of the treatment of tonsillitis except for the fact that it is here that homeopathic medication seems paramount. As an additional precaution I always have the patients gargle with a 5 per cent. solution of Potassium Chlorate or a 30 per cent. solution of Hydrogen Peroxide in water.

Another winter disease which often complicates the puerperium and simulates puerperal sepsis is influenza. A careful study of the case, however, will lead to differentiation. We should remember that puerperal sepsis almost invariably begins between the second and fifth days, and is ushered in suddenly with a chill and a high fever, whereas grippe attacks the organism more gradually with pronounced malaise and with catarrhal symptoms never occurring with puerperal sepsis. Our best differentiation, however, comes with the leucocytosis of sepsis and the leucopenia or normal blood count of influenza. Blood cultures, when they can be obtained, are also dignostic, but in my hands they have been absolutely without result—being able to obtain no bacterial growth whatsoever.

Malaria is a disease which I fear is greatly overestimated as a cause of chill followed by fever during the puerperium. Few people living in our city and who have been living here exclusively

are affected with it. Unless we can get a clear cut history of the chills and fever occurring prior to the delivery, there is little use in supposing that we have a malarial infection subsequent to delivery. This is particularly true during the winter months since it has been convincingly proven that the malarial plasmodium is transmitted by the bite of the mosquito. A regular chill, fever and sweat followed by a free interval, and occurring in cases delievered during the four summer months when mosquitoes are abundant, should be suspected of harboring the malarial organism. In such cases a blood examination for the intercorpustular refractive bodies is indicated. If these are not found after several examinations, we should abandon our diagnosis of malaria as being untenable and look elsewhere for the source of the fever. We are by no means justified in giving the patient maximal doses of Quinine while just recovering from the stress of a labor on the mere assumption that she has malaria. I feel that this statement is best understood when we recall that Quinine lessens the coagulability of the blood, reduces the number of leucocytes, and lessens their amœboid movements. If the case is really one of puerperal sepsis, it can readily be seen that Quinine is strictly contra-indicated since, in this condition, a high leucocytosis with readily movable white cells affords us a more favorable prognosis.

By most of the laity and by some physicians, the onset of lactation is considered a cause for elevation of temperature. I personally do not feel that any temperature over 100° F. is caused by the breasts beginning their secretion. This ought to be considered a physiological process. The mere fact that the onset of lactation, beginning as it does on the second or third day, about the time when we look for fever occurring from infection, seems to have been the cause for the belief that oftentimes the fever is due to lactation itself.

On the other hand, breast infections are very prone to occur during the puerperium. These are sometimes of insidious onset and do not begin with the classical symptoms of chill followed by marked rise in temperature. In fact, one case which I have recently seen was accompanied by no febrile disturbance whatsoever. Four days after delivery a nurse in applying a breast binder to a patient noticed a lump in the breast. Strangely, this

did not increase appreciably in size, presented no fluctuating areas, and the patient felt no discomfort. In addition, as I have mentioned before, there was no febrile disturbance. Naturally, the lump was mistaken for a tumor. Three weeks after the delivery, or some eighteen days after the tumor was first noticed, and after the secretion of milk had been checked, the breast was operated upon. To our great surprise, we found that the neoplasm was not a tumor but an encapsulated breast abscess. I have not seen any reports of a similar case in the literature, and it would seem that the lack of growth, the absence of pain, the lack of fluctuation, and the afebrile character of the temperature would have conclusively ruled out the diagnosis of breast abscess. In a case like this, a tubercular mastitis would naturally be supposed but subsequent investigation did not bear out our supposition.

During the past winter I have seen another type of breast infection in two cases. The inflammation was evidently parenchymatous and had an acute onset with fever of 103° F., with rapid pulse, dry mouth, muscular pains, and a swollen painful breast with indurated areas. The prompt application of flaxseed poultices, day and night, with catharsis and the indicated remedies, which in both cases proved to be Belladonna and Hepar, led to a decline of the fever by lysis in three days and the disappearance of the indurated areas in the breast. I have been inclined to think that in both these cases instead of having the usual staphylococcus or streptococcus infection that we have been dealing with a localized infection by the bacillus influenza of Pfeffer, which has caused so many cases of grippe this winter.

A very common cause of fever after childbirth and one for which practitioners are ever on the alert is due to intestinal putrefaction. These cases are characterized by a low grade of temperature, rarely reaching 103° F., and abdominal distension with colic. This latter symptom seems most characteristic. Many of these cases yield but poorly to treatment. It has been my experience that whenever the distension is relieved, the temperature drops. It is true too that the distension seems to occur upon the slightest provocation. At times treatment seems to be of no avail in relieving the ballooned intestines. I have seen cases where I have prescribed the homeopathic drugs having a similar symptomatology to the best of my ability with no appreciable result. Fol-

lowing this line of treatment, I have used enemata, both simple and compound, with but slight results. Then I have prescribed cathartics—vegetable, saline and mercurial, with hardly any better results. The diet has been carefully supervised and all putrefactive material has seemed to have been removed from the intestines, and yet the distension and colic have remained. I have, however, found three drugs to be of use. The first is Pituitrin, given in doses of 1 cc. hypodermatically, every three hours, and repeated three times if necessary. This will sometimes relieve the distension if the musculature of the bowel has been temporarily paralyzed. The next drug that I have found to be of value is Eserine, given in doses of 1/50 of a grain, hypodermatically, every two hours for three doses if necessary. It has been my experience that the third dose is rarely needed. Acting as a stimulant to the peripheral endings of the autonomous nervous system in the intestines, Eserine Salicylate or Physostigmine Salicylate, as it is sometimes called, seems to be able to produce peristalsis when nothing else will. The last remedy, and by no means the least in importance, is Lactobacilline. This is a Metchnikoff preparation of the Bacillus Bulgaricus in liquid suspension, and is, I believe, far more efficacious than tablets purporting to contain the same bacteria. Lactobacilline has no value in ridding the intestines of their gaseous accumulation, but it will aid in destroying the cause of the intestinal fermentation and limit the recurrence of distension.

I have purposely left the largest and most interesting group of the causes of puerperal fever until last. This group is loosely classified as "puerperal sepsis." In reality, it embraces three different types, true septicemia, sapremia and pyemia. The most frequent cause of sapremia and pyemia is the retention of some of the products of conception. In fact, obstetrically, we can have neither of these conditions unless there is a septic focus in the genital tract. One of the most characteristic symptoms of this condition is a foul odor to the lochia; in fact, upon entering the ward it is often possible to tell whether there is a patient suffering from this condition there. Usually there are both chills and fever, but neither of these is as severe as in a true septicemia. The fever seldom ranges above 103° F., but it is apt to rise higher if allowed to go without treatment. Thrombophlebitis is not an infrequent complication of both these types of fever.

The treatment is obvious and largely preventive. We should be reasonably sure that all the membranes are removed. This is not as easy a task as it may seem since often little tags of membrane may tear off and be left behind. Again, I have seen large pieces of membrane left in the uterus for some days and then expelled in a non-infected condition. Having determined that we have a sapremia, the bed should be elevated and some attempt made to remove the septic focus from the uterus. As to how this should be done, opinions differ. I believe that a sterile gloved finger or placental forceps may be introduced into the uterus with impunity and its contents removed. The use of a curette is not permissible. Following the removal of the foreign material, the uterus may safely be swabbed out with Iodine gauze. This may be repeated if necessary. Vaginal douches are indicated only if the odor is offensive. Intrauterine douches may be given but are seldom indicated. Before using any variety of douche, it is well to remember the possibility of carrying the infection up into the tubes and from there to the peritoneal cavity. This may occur even without douching, but the douche certainly aids it. Echinacea has appealed to me very strongly as a drug for these cases. If the fever is high, alcohol or gelatin in some form should be given since both these foods are protein sparers and combat the catabolism or destructive processes inaugurated by the fever and aid us in supporting the patient's strength. Quinine is never indicated, although it is sometimes given to combat the hyperpyrexia. It seems, however, that cold air and cold sponges are better therapeutic agents than antipyrine drugs which tend to destroy the leucocytes.

Turning finally to true septicemia we find a condition feared by every obstetrician. I feel that no matter how careful our technic we will meet these cases in our practice. I need quote but one case to show what I mean. This fall I had a woman under my care who had never been examined, vaginally, throughout the course of a perfectly normal labor. She was delivered with a perfectly aseptic technic—no part of the operator coming in contact with the perineum except by means of gloves and a sterile towel. A lysol towel covered the rectum. After the baby was born the perineum and vaginal mucous membrane were carefully examined in a good light for any lacerations, but there was not even a

scratch evident. In addition, I have reason to believe that the post-partum care was as aseptic as the delivery, and yet this case developed a true septicemia.

Septicemia, as its name indicates, is caused by bacteria themselves entering the blood stream. It is well to remember that this may be, and usually is, secondary to pyemia or sapremia. When it occurs alone it is characterized by a sharp chill occurring on the second to the fourth day followed by a high fever bordering on 105° F. with a morning remission. In uncomplicated septicemia there is almost never a lochial odor. If the patient's resistance is good, there is a very high leucocytosis, usually around 60,000. The amount of leucocytosis may give us some hint as to the prognosis—a small number of leucocytes indicating a lowered resistance on the part of the patient and an unfavorable outcome. Provided our treatment is successful, the fever declines by lysis, reaching normal about the tenth day. With septicemia it is often possible to obtain blood cultures of the etiologic bacillus microorganism.

Since the ultimate result depends purely upon the patient's resistance, it is for us as physicians to aim to conserve the strength of the patient, reduce the fever, and stimulate if necessary. I believe that as yet we have no reliable means of killing live bacteria in the blood stream unless it is by means of a definite serum such as Marmorek's antistreptococcic serum which contains specific bacteriolysins. This may safely be given in all cases, but we should not stop at a small dose but give 30 cc. at a time. Intravenous injections of Magnesium Sulphate have been used for the same purpose, but I still hesitate to use it owing to its effect upon the central nervous system. If there is septic material in the uterus, it should be removed, the bed elevated, and the patient put in a quiet room with no visitors except the husband or mother, and these only for short periods. The diet should be of the very lightest, and gelatin or alcohol in some form administered at fairly regular intervals. Strychnine or Digalen may be used as necessary. Echinacea and Pyrobenum deserve a close study, homeopathically. With the temperature above 102° F. alcohol sponge baths should be used every three hours. Another great therapeutic aid, and one which is often neglected, is to have the windows wide open, provided that the patient is not in a

draught. I believe that fresh air is as important in the treatment of this condition as it is in pneumonia.

Vaccines and Phylacogens are used to treat this condition, but they have made no impression on the course of the disease in my hands. Theoretically, it would seem that the infection itself had stimulated all the natural forces of the body that it was possible to call upon, and that it would be impossible for vaccines to aid any further in this way. It appears that the addition of further toxic material to the blood stream in the form of vaccines is only aggravating the condition. It seems, though I have never tried it or heard of its being tried, that the time to use vaccines is at the time of delivery. I believe that if all our patients were given a prophylactic dose of vaccine, preferably the mixed variety, at the time of delivery, that we would see fewer cases of post-partum sepsis. Again, if we are to believe Dr. Davis, of Chicago, it is not the particular vaccine that causes the immunity to infection, but rather the injection of any foreign proteid into the blood stream with the resulting hyperpyrexia and leucocytosis.

Another line of treatment which may be of aid is the giving of from one-quarter to one-half of a yeast cake in either capsules or in warm water. Yeast is one substance which will raise the number of leucocytes in the blood and have no ill effect upon the organism.

In uncomplicated septicemia we should remember that we are dealing with a disease involving the entire organism, and local uterine or vaginal treatment is of little or no avail. A fever lasting longer than two weeks almost invariably indicates a suppurative parametritis. Vaginal examinations aid us in determining this—induration or fluctuation in the broad ligament or cul-de-sac being pathognomonic even though in one case I saw that it ran a temperature for over a month, neither of these could be elicited. Yet when a laparotomy was performed as a last hope of finding the source of trouble, the pelvis was found to be full of pus. Of course, there is but one treatment for this condition and that is drainage.

The division of diseases into general and local seems to have been commonly observed.—*Organon of the Rational Art of Healing.*

Alumni Notes

'07. O. J. Case, of Buffalo, has recently entered the United States Navy as Lieutenant, being attached to the Naval Reserve Battalion at Buffalo.

'94. E. S. Munson, of New York, has recently been promoted to the Second Lieutenancy of Company C, Seventh Regiment Infantry, of New York.

'13. B. L. Cunningham, of Jamaica, has recently received a commission in the Medical Corps of the United States Navy, and is now on duty at the Naval Hospital at Portsmouth, N. H.

We note the following changes of address: Brooklyn, N. Y. '70. J. T. Deyo, 821 Beverly Road; '15, W. A. Lucia, 1372 64th street; '03. W. J. Quinn, 2346 Cornelia street; '11. M. F. Searle, 34 Plaza.

'12. P. W. Bergen is now located at 143 Second Avenue, Astoria, N. Y.

'87. D. H. Arthur has removed to 144 Fisher Avenue, White Plains, N. Y.

'01. J. H. Fobes, F. A. C. S., has recently been appointed consulting surgeon to the McKinley Memorial Hospital, of Trenton, N. J.

'00. F. M. Dearborn has been appointed consulting dermatologist to the new Charlotte Hungerford Memorial Hospital of Torrington, Conn.

'05. Harry C. Sayre, of Warwick, N. Y., was married on March 27, 1917, to Miss Alice Skeehan, of Ridgewood, N. J., at the Marble Collegiate church in New York City. Congratulations!

'16. W. G. Herrman is now located at the Metropolitan Hospital, Blackwell's Island, N. Y. City.

'02. W. Frank Fowler was elected President of the Monroe County Homeopathic Society at the annual meeting in January, 1917.

'03. E. Welles Kellogg has been elected Recorder of the Society of American Wars, Commandery of the State of New York.

'07. J. B. Gregg Custis is receiving condolences upon the death of his mother, widow of the late J. B. Gregg Custis, class of 1876. Mrs. Custis died on February 24th, 1917.

'82. Abner G. Downer has recently returned from abroad, and his correct address is 515 South Main Street, Princeton, Ill.

'92. Sidney E. Smith, of 78 Arlington Avenue, Brooklyn, N. Y., is alive and kicking in spite of the fact that one of our correspondents reported his death to us a few months ago.

'99. Alfred Bornmann has been elected President of the Kings County Homeopathic Medical Society.

'10. J. R. Bramley, who recently went west, to Loveland, Colo., has bought out a practice and moved to Denver, Colo.

'06. A. G. Cranch has taken charge of the hospital and employees' welfare work of the General Electric Company at Erie, Pa. Dr. Cranch also expects to take a house in Lawrence Park, the G. E. residence suburb of Erie, where he will open an evening office of his own. He should be addressed, Care of General Electric Co., Erie, Pa.

'00. F. M. Dearborn addressed the annual meeting of the Northeastern Alumni Association of the Hahnemann Medical College of Philadelphia in Scranton on April 19, 1917, in the interests of the American Institute of Homeopathy.

'14. F. G. Miller is now located at 404 West 23rd Street, New York City.

'15. H. D. Mitchell, of Fort Worth, Texas, recently spent some time in Rochester. When he left he took a wife with him, having married the daughter of Doctor and Mrs. S. R. Snow, Miss Jane Warren Snow. Congratulations!

'14. R. J. Levy announces the removal of his office to No. 302 Central Park West, New York City.

'14. M. S. Lemlich has changed his address to No. 496 Hopkinson Avenue, Brooklyn, N. Y.

'14. H. L. Pender's correct address is 196 Genesee Street, Utica, N. Y.

'15. Robin Hood married, on March 3, 1917, Miss Juna Hix, of Binghamton, N. Y. Dr. Hood resides at 500 West 140th Street and has an office at 772 Park Avenue, New York City.

'15. J. A. Hoegen is located at 608 Dixwell Avenue, New Haven, Conn.

'01. S. A. Beckwith is receiving condolences upon the death of his father.

'08. F. M. Smith, of New York, has taken the required examinations and entered the United States Navy. He is now surgeon on a battleship.

'01. Roy Upham announces that after March 1, 1917, his practice will be limited to the diagnosis and treatment of surgical conditions of the digestive system.

'04. S. S. Jacquelin is owner and director of a boys' camp in the Adirondack Mountains. The camp is called "Camp Beacon," and is situated on Long Lake. Any one interested in such a camp may obtain a fully illustrated booklet from L. Woodruff, A. M., Headmaster of the camp, 107 West 76th Street, New York City.

'91. H. W. Foster and H. A. Foster, '00, recently lost their father, his death taking place about the middle of April in Putnam, Conn. We extend our sympathy to the Brothers Foster.

A second division of diseases into febrile and afebrile, though highly esteemed, labors under a similar disadvantage. There is no general agreement as to which characteristic signs and symptoms should be included in the definition of fever, and which should be rejected; and among the greater number of theories and definitions of fever there is none that does not include symptoms which are also found more or less in diseases which are considered among the most afebrile. The most febrile pass over into the most afebrile by imperceptible degrees, a fact which shows that a sharp division between the two is only artificial and not natural.—*Organon of the Rational Art of Healing.*

But the human body is, in its living state, a unity, a complete and rounded whole. Every sensation, every manifestation of force, every inter-relation of the material of one part, is intimately concerned with the sensation, force-manifestations and inter-relations of all the other parts; no part can suffer without involving all the rest in suffering (greater or less) and in alterasion.—*Organon of the Rational Art of Healing.*

Obituary

FRANK D. MAINE, CLASS OF 1872.

Dr. Frank D. Maine, of Springfield, Mass., died at the Hampden Hospital, Springfield, on October 29, 1916. He was seventy-seven years of age and a veteran of the Civil War.

CONSTANTINE H. MARTIN, CLASS OF 1868.

Dr. Constantine H. Martin, aged seventy-one, died at his home in Allentown, Pa, on February 5, 1917, from cerebral hemorrhage. Dr. Martin was a Civil War veteran.

CHARLES S. MACY, CLASS OF 1881.

Dr. Charles S. Macy died at his home in early April. Dr. Macy's interest in Homeopathy was well known; he was a member of the American Institute of Homeopathy, the Homeopathic Medical Society of the State of New York, New York Homoeopathic Materia Medica Society, Meissen Club and the Unanimous Club. He was Professor of Medical Gynecology in his Alma Mater for many years prior to 1906.

ARTHUR A. VIBBARD, CLASS OF 1894.

Dr. Arthur A. Vibbard, at the age of forty-nine, died at his home in Albany on January 19, 1917, pneumonia causing his death. Dr. Vibbard formerly resided in Johnstown, N. Y. Having graduated from the New York Homeopathic Medical College in 1894, he practiced for a few years in Gloversville, where his wife died. He then went to Albany, where he confined his practice to eye, ear, nose and throat work. He was a prominent Albanian, and took an active part in civic affairs. He leaves one daughter, Dorothy Adele, and one son, Earl. The services were held in Albany and the remains interred at Johnstown.

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